

# National Health Service Corps

For years, the Public Health Service has provided grant funds to support health care programs, or has provided such programs, for certain segments of the population, such as the Indians, Alaskan natives, and merchant seamen.

With the establishment of the National Health Service Corps, the Public Health Service of the Department of Health, Education, and Welfare is pioneering in an effort to provide health care services for the general population living in areas where there is a critical health manpower shortage.

The Corps was established as part of an overall health manpower strategy to deal with the problems that maldistribution of health care providers has created, because of geography and because of the uneven availability of medical specialists.

This maldistribution of health care providers is demonstrated by 1970 data, which show 69.1 physicians per 100,000 population in rural or nonmetropolitan counties, approximately half the provider coverage available in metropolitan counties.

Between 1967 and 1972, the number of physicians offering primary care in rural areas decreased 7% and the numbers of pharmacists, nurses, dentists, and podiatrists serving in rural America also declined.

The new approach to the problem of rural health that the National Health Service Corps represents is the assignment of personnel to improve the delivery of health care and to link these health professionals in a very important personal and professional way to communities and to patients with needs and problems.

The placement of personnel in critical health manpower shortages adds a health resource to people who in many cases have not had other than emergency care available for long periods of time, and who have had to travel substantial distances even for that care.

But a Corps placement is also an essential step in assisting such communities to develop the capability to attract and retain health professionals long after the Corps placement has been ended.

There are built-in steps to achieving this form of community-based development. The first is an essential part of the Corps' consideration of a community for the placement of personnel. The local governing body, the local planning agency, and professional societies, medical or dental, document the need for assistance. These organizations are the key to the cooperative effort of the community in the management and development of a successful medical or dental practice. They are in a position to offer assurances that the community will provide whatever support it can in such development, including office equipment, supplies, and management of the practice.

Especially critical to the community's request for Corps assistance is the county medical society, which participates in an assessment of the community's health needs. The society can provide advice on the numbers and types of health professionals needed and equipment that will be required to establish an active primary care practice.

Just as important, the acceptance of the Corps physician by his peers is a very real factor that can influence his remaining in the community. The medical society can facilitate the integration of the physician and his wife into the medical community, help in obtaining hospital staff privileges, and facilitate a mechanism to form rotational coverage in the evenings and on weekends. The medical society also can identify health resources both locally as well as backup resources that may be needed for tertiary care.

Once a community is selected for a Corps placement, the Corps program provides support in developing a well-functioning practice. It has developed a problem-oriented medical record system and accounting and data system that the physician may use. It can help develop linkages for the physician with the local hospital, the appropriate medical society, as well as with a medical center or school near the community.

The Corps physician functions as does any other practicing community physician. He is there to serve people. He works closely with local physicians, who help him determine fees of service. No person is denied care because he is unable to pay, and a sliding scale may be used if needed.

In January 1972, the first group of health professionals, primarily physicians, dentists, and nurses, were placed in a dozen communities. Of the 89 clinic sites that have been providing services since that time, approximately 25% have become independent and no longer receive direct federal support.

As of June 30, 1974, 206 Corps sites were in operation, and a total of 323 communities were approved for the placement of health manpower teams. Providing health care at the operable sites were physicians, dentists, nurses, and other health professionals.

By July 1975, the Corps is proposing to have 310 clinic sites in operation and a total of 430 areas approved for health teams. This would involve more than 800 health professionals who would be delivering needed health care in 46 sites.

Of the 189 clinic sites in operation prior to July 1974, 48 are now fully self-sustaining and repay to the US Treasury all costs of the assignee's salary, fringe benefits, and expenses involved in moving to the location.

Within the next year, the Corps expects more clinics to become independent. It appears that the low retention rate of physicians has now been reversed. While only 3% of the assignees decided to remain in the Corps in 1973 after their first service period, 20% will remain in 1974. This is largely due to improved management techniques at the sites and more careful matching of assignees with the communities. There is also increased emphasis on recruitment of board-eligible physicians who need not leave a community for further professional training.

EDWARD D. MARTIN, MD  
Office for National Health Service Corps  
Parklawn Bldg, Room 6-05  
5600 Fishers Lane  
Rockville, MD 20852